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EXPOSED PERSON

Needlestick Injury, Blood/Body, Fluid Request Form

FOLLOW UP BLOOD TEST FORM

3 MONTH POST NEEDLESTICK EXPOSURE

EXPOSED PERSON DETAILS			
NHI (if known)		**DOB**	dd/mm/yyyy
Surname		**Given Name**	
Gender	Male ☐ Female ☐	**Phone No.**	
Address			
Date of Exposure			

CONTACT PERSON MANAGING RESULTS & GP DETAILS – Please complete all fields to ensure no reporting delays (e.g. GP, Dentist, Workplace Occupational Health/Infection Control Person)			
Name of Requesting Clinician		**Location**	Name of Medical Centre/Dental Surgery
Contact Nos.	Daytime:	**NZMC #**	
	After Hours:	**Mobile No.**	
Please send a copy of results to GP : ☐ Yes ☐ No			
GP Details (Name & Location)			

SPECIMEN RECEPTION & ULTRA REGISTRATION INSTRUCTIONS	
Nova	**Test**
HEG	☐ Hepatitis B Surface Ag (diagnosis)
HEB	☐ Hepatitis B Surface Ab (immunity)
HIV	☐ HIV
HCV	☐ Hepatitis C

SPECIMEN REQUIREMENTS

Collect 5mL Yellow SST tube *(Alternative tubes if SST/Yellow Top tube is unattainable: EDTA (Mauve tube), Heparin, Sodium Citrate, ACD, CPD tube).* **Label Specimen Correctly.**

INFORMED CONSENT BY EXPOSED PERSON FOR BLOOD TESTS & PROPHYLAXIS

I understand the risk of infection following accidental blood/body fluids exposure and I'm aware of the treatment options. I agree to have the following blood tests performed. Tests for Hepatitis B, C and HIV will be performed unless excluded *(please cross out to exclude)*

☐ Hepatitis Bs Ag (Diagnosis) ☐Hepatitis Bs Abs (Immunity) ☐Hepatitis C Abs ☐ HIV Abs/Ag

Signature: _____ Date: _____

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EXPOSED PERSON

Needlestick Injury, Blood/Body, Fluid Request Form

FOLLOW UP BLOOD TEST FORM

6 MONTH POST NEEDLESTICK EXPOSURE

EXPOSED PERSON DETAILS			
NHI (if known)		**DOB**	dd/mm/yyyy
Surname		**Given Name**	
Gender	Male ☐ Female ☐	**Phone No.**	
Address			
Date of Exposure			

CONTACT PERSON MANAGING RESULTS & GP DETAILS – Please complete all fields to ensure no reporting delays (e.g. GP, Dentist, Workplace Occupational Health/Infection Control Person)

Name of Requesting Clinician		**Location**	Name of Medical Centre/Dental Surgery
Contact Nos.	Daytime:	**NZMC #**	
	After Hours:	**Mobile No.**	
Please send a copy of results to GP : ☐ Yes ☐ No			
GP Details (Name & Location)			

SPECIMEN RECEPTION & ULTRA REGISTRATION INSTRUCTIONS	
Nova	**Test**
HEG	☐ Hepatitis B Surface Ag (diagnosis)
HEB	☐ Hepatitis B Surface Ab (immunity)
HIV	☐ HIV
HCV	☐ Hepatitis C

SPECIMEN REQUIREMENTS

Collect 5mL Yellow SST tube *(Alternative tubes if SST/Yellow Top tube is unattainable: EDTA (Mauve tube), Heparin, Sodium Citrate, ACD, CPD tube).* **Label Specimen Correctly.**

INFORMED CONSENT BY EXPOSED PERSON FOR BLOOD TESTS & PROPHYLAXIS

I understand the risk of infection following accidental blood/body fluids exposure and I'm aware of the treatment options. I agree to have the following blood tests performed. Tests for Hepatitis B, C and HIV will be performed unless excluded *(please cross out to exclude)*

☐ Hepatitis Bs Ag (Diagnosis) ☐Hepatitis Bs Abs (Immunity) ☐Hepatitis C Abs ☐ HIV Abs/Ag

Signature: _____ Date: _____

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